J-1 VISA PHYSICIAN VERIFICATION OF EMPLOYMENT FORM

PHYSICIAN NAME:_____

EMPLOYMENT START DATE: _____

INS J-1 Visa Waiver Approval Date: _____ H-1(b) Visa Approval Date: _____

HOME ADDRESS:
Street: _____

City:_____ State _____ Zip Code: _____

Home Phone: (_____)_____

Type of Medical Practice _____

Location of Medical Practice_____
Street

_____ _____ _____ _____
City County State Zip Code

_____
HPSA (include specific County, C.T., CCD, BORO, etc.)

Phone: _____ FAX: _____

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE ABOVE STATED LOCATION(S) A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician's Signature Date
(Notary)

EMPLOYER/SPONSOR:

I HEREBY CERTIFY THAT DOCTOR_____ BEGAN

PRACTICING AT_____ ON _____
AND PROVIDES A MINIMUM OF 40 HOURS PER WEEK OF PRIMARY HEALTH CARE IN THE ABOVE LISTED HPSA LOCATION(S).

_____ _____
Employer/Sponsor's Signature Date
(Notary)

RETURN THIS FORM TO THE FOLLOWING:

MISSISSIPPI STATE DEPARTMENT OF HEALTH
OFFICE OF PRIMARY CARE LIAISON
570 EAST WOODROW WILSON - P. O. BOX 1700
JACKSON, MISSISSIPPI 39215-1700
TELEPHONE #: 601-576-7216
FAX #: 601-576-7230

(Reporting form will be forwarded to the appropriate federal sponsoring agency)